FH [redacted]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: MOP - 165072

PRELIMINARY RECITALS

Pursuant to a petition filed on April 2, 2015, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Office of County Attorney regarding Medical Assistance, hearings were held on April 28, 2015, September 29, 2015 and October 27, 2016, by telephone. The record was held open post-hearing for additional evidence from the county agency.

The issue for determination is whether the agency properly seeks to recover an overissuance of BC+ benefits from the Petitioner in the amount of $5,472.42 for the period of November 1, 2012 – January 31, 2014.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Petitioner's Representative:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: [redacted]
Office of County Attorney
432 E. Washington Street
Suite 3029
West Bend, WI 53095

ADMINISTRATIVE LAW JUDGE:
Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Washington County.

2. Petitioner's two children were enrolled in BC+ with a monthly premium of $20 from at least May 1, 2012 through August 31, 2012.

3. On August 14, 2012, the Petitioner contacted the county agency. The case comments state: "Call from PP to report that she is no longer employed as of yesterday. States her insurance through her employer will end 8/31/12 and would like to be added to BC. Updated request date and EI screen. Case pending for verification of employment ending and last stub. Gave PP CDPU fax number. Advised to allow 10 days for processing and she would receive a NOD in the mail regarding eligibility. Verification due 8/24/12."

4. On August 23, 2012, the agency received a faxed pay statement and verification that Petitioner's employment ended with her previous employer [redacted].

5. On September 7, 2012, the Petitioner contacted the agency. The case comments state: "Call from Jennifer at 12:45 p.m. – wondering if she is elig for BCPA in 9/2012. Income and ins ended. If got another ck it would have been on 8/28/2012. Claims last ck was 8/12 though. Updated case for 9/2012 w/no income. BCPA opens."

6. On September 10, 2012, the agency issued a Notice of Decision to the Petitioner at her address on [redacted]Kewaskum informing her that she and her two children were enrolled in BC+ Standard Plan with no monthly premium effective September 1, 2012. This was based on $0 household income. The notice stated that Petitioner and her children would receive the health care benefits "until there is a change in your case." The notice further informed the Petitioner of the requirement to report to the agency within 10 days if she "has a change in health insurance coverage." It also informed her of the requirement to report to the agency by the 10th day of the next month if her gross monthly household income exceeded $1,590.83. It stated as follows: "If you don't report a change listed above, and you get benefits or coverage that you aren't eligible for, you may have to pay us back." There is no indication in case comments that the notice was returned to the agency as undeliverable.

7. On September 18, 2012, October 15, 2012, February 25, 2013, and March 19, 2013, the agency issued notices to the Petitioner at her address on [redacted] Kewaskum regarding her enrollment in a BC+ HMO. There is no indication in case comments that the notices were returned to the agency as undeliverable.

8. On April 15, 2013, the agency issued an Enrollment and Benefits Information booklet to the Petitioner at her address on [redacted], Kewaskum. There is no indication in case comments that the notices were returned to the agency as undeliverable.

9. On April 15, 2013, the agency issued a notice to the Petitioner at her address on [redacted], Kewaskum regarding a renewal of her benefits. The notice states: "We have reviewed your case and based on our records, your BadgerCare Plus Standard Plan benefits will continue. Our records show that your household income is below $957.50 per month. Our records also show that your household does not have health insurance through a job. If your income goes over the limit listed above, or you get health insurance through a job, you must report the change(s) to us right away. See the back of this letter." The notice continues:

> "Must I contact the agency to make sure my benefits continue? No. Your benefits will be continued based on the information we already have. Only contact your agency if your income is higher than the amount listed on page 1.

What kinds of changes must I report? . . . You sign up for other health insurance. . . Your income changes.

What will happen if I do not report changes? You may have to pay money back for benefits you received incorrectly.

How do I report changes? Online . . . By mail . . . By phone . . .”

There is no indication in case comments that the notice was returned to the agency as undeliverable.

10. On January 18, 2014, the agency received an employment discrepancy alert that the Petitioner was employed with [redacted]. On January 18, 2014, the agency contacted [redacted] and requested verification of employment and wages for the Petitioner.

11. On January 20, 2014 and February 6, 2015, the agency received actual wage verification from Petitioner’s employer [redacted]. The verification reported that the Petitioner was employed since August 20, 2012, 40 hours/week at $21.12/hour. It states that health insurance was available to the Petitioner beginning January 1, 2014 and that the employer paid 80% or more of the insurance. The Petitioner’s gross pay was reported as follows:

August, 2012	$ 817.37	January, 2013	$4,801.16
September, 2012	$3,173.97	February, 2013	$3,288.53
October, 2012	$3,182.24	March, 2013	$3,959.00
November, 2012	$3,126.99	April, 2013	$3,678.00
December, 2012	$3,129.88	May, 2013	$3,547.00
		June, 2013	$3,589.00
		July, 2013	$3,689.00
		August, 2013	$5,292.00
		September, 2013	$3,644.00
		October, 2013	$3,672.00
		November, 2013	$3,607.00
		December, 2013	$3,515.00
January, 2014	$5,210.97		
February, 2014	$4,841.30		
March, 2014	$3,374.89		

12. Petitioner received child support income during the overpayment period. The Petitioner’ gross household income, including earned income and child support income was as follows:

August, 2012	$2,852.01	January, 2013	$5,539.67
September, 2012	$4,114.84	February, 2013	$3,826.77
October, 2012	$4,104.17	March, 2013	$4,510.47
November, 2012	$3,856.50	April, 2013	$4,618.93
December, 2012	$3,790.58	May, 2013	$4,300.57
		June, 2013	$4,347.78

July, 2013	$4,471.14
August, 2013	$6,010.78
September, 2013	$4,334.46
October, 2013	$4,712.69
November, 2013	$4,392.46
December, 2013	$4,265.46
January, 2014	$6,021.43

13. On February 10, 2014, the Petitioner reported an address change to the child support agency. The county IM agency was notified of the change and the Petitioner's BC+ case file was updated with the new address.

14. On February 24, 2015, the county agency issued Wisconsin Medicaid and Badgercare Plus Overpayment Notices and worksheets to the Petitioner informing her that the agency intended to recover BC+ overissuances due to client error in failing to report new employment and income exceeding the program limit. The Notices informed her that the agency intended to recover the following overissuances:

November 1, 2012 – October 31, 2013	$6,950.81 (for Petitioner's benefits)
November 1, 2012 – October 31, 2013	$1,075.26 (for Petitioner's children's benefits)
November 1, 2013 – January 31, 2014	$2,241.34 (for Petitioner's benefits)
November 1, 2013 – January 31, 2014	$ 371.06 (for Petitioner's children's benefits)

Total amount of the overissuances sought was $10,815.33. The overissuance amounts included net capitation payments of $2,050.11 made by the agency on behalf of the Petitioner, paid claims of $7,142.04 made by the agency on behalf of the Petitioner and monthly capitation or premium payments for Petitioner's children of $1,623.18.

15. On April 2, 2015, the Petitioner filed an appeal with the Division of Hearings and Appeals.

16. As of the date of this decision, the Petitioner's private insurer had reimbursed the county agency for some of the medical claims paid by BC+ on behalf of the Petitioner. The county agency revised the amounts it seeks to recover as BC+ overissuances as follows:

November 1, 2012 – October 31, 2013	$2,841.41 (for Petitioner's benefits)
November 1, 2012 – October 31, 2013	$1,075.26 (for Petitioner's children's benefits
November 1, 2013 – January 31, 2014	$1,184.69 (for Petitioner's benefits)
November 1, 2013 – January 31, 2014	$ 371.06 (for Petitioner's children's benefits)

Total amount of the overissuance has been revised to $5,472.42. The overissuance amounts include net capitation payments of $2,050.11 made by the agency on behalf of the Petitioner, paid claims of $1,975.99 made by the agency on behalf of the Petitioner and monthly premium payments for Petitioner's children of $1,623.18.

DISCUSSION

The Department of Health Services, through its county agencies, is legally required to seek recovery of incorrect BC+ payments when a recipient engages in a misstatement or omission of fact in applying for or receiving BC+ benefits, or fails to report income or other information affecting eligibility and benefits, which in turn gives rise to a BC+ overpayment:

> 49.497 Recovery of incorrect medical assistance payments. (1) (a) The department may recover any payment made incorrectly for benefits provided under this subchapter or s.49.665 if the incorrect payment results from any of the following:
>
> > 1. A misstatement or omission of fact by a person supplying information in an application for benefits under this subchapter or s.49.665.
> >
> > 2. The failure of a Medical Assistance or Badger Care recipient or any other person responsible for giving information on the recipient's behalf to report the receipt of income or assets in an amount that would have affected the recipient's eligibility for benefits.
> >
> > 3. The failure of a Medical Assistance or Badger Care recipient or any other person responsible for giving information on the recipient's behalf to report any change in the recipient's financial or nonfinancial situation or eligibility characteristics that would have affected the recipient's eligibility for benefits or the recipient's cost-sharing requirements.
>
> (b) The department's right of recovery is against any medical assistance recipient to whom or on whose behalf the incorrect payment was made. The extent of recovery is limited to the amount of the benefits incorrectly granted. …

Wis. Stat. §49.497(1). BC+ regulations are in the same subchapter as §49.497. See also, BC+ Eligibility Handbook(BCPEH), §28.1.

BC+ recipients must report changes in circumstances that could impact their eligibility for benefits, including changes in health insurance coverage and when their income exceeds certain levels. BCPEH, §§27.2 and 27.3.

In this case, the agency asserted that the Petitioner requested to be added to BC+ in August, 2012 when she called to report that her job at [redacted] was ending. The agency argued that the Petitioner did not notify the agency when she obtained new employment at [redacted], did not report when her gross monthly income exceeded the reporting requirement of $1,590 and did not report when she had a change in health insurance coverage. The agency produced evidence demonstrating that it issued a notice to the Petitioner at her correct address informing her that she and her children were enrolled in BC+ effective September 1, 2012 with no monthly premium. Additional notices were issued to the Petitioner throughout 2012 and 2013 regarding her BC+ benefits. The agency produced evidence of the Petitioner's gross monthly income demonstrating that she exceeded the reporting requirements in September, 2012, requiring her to report the increase in income to the agency by October 10, 2012. This would have impacted her benefits beginning November 1, 2012. The agency produced evidence that the Petitioner and her children had changes in health insurance coverage beginning in October, 2012 and Petitioner was required to report those changes to the agency within 10 days.

At the final hearing on October 27, 2016, the Petitioner argued that she never requested to enroll in BC+ and was unaware that the agency had enrolled her. She testified that she never received any notices of her enrollment or benefits and never received any explanation of benefits. She testified that she did not tell any of her providers to bill BC+ because she had insurance through her employer. She further argued that, with regard to her children, she stopped paying monthly premiums and therefore coverage for the children should have ended. She argued that any continuation of coverage for the children was an error by the agency. In addition, the Petitioner asserted that she informed the agency of her new employment when she contacted the agency in August and September, 2012.

I find the Petitioner's testimony at the hearing on October 27, 2016 that she did not request to enroll in BC+ and was unaware that she had been enrolled to be self-serving and not credible. At the initial hearing on April 28, 2015, the Petitioner testified that she needed coverage beginning September 1, 2012 because her employer-sponsored insurance at [redacted] would end on August 31, 2012 and she would not have insurance beginning September 1, 2012. Her testimony at the final hearing that she never requested BC+ is not credible, given her previous testimony and the fact that she conceded she would have had no insurance beginning September 1, 2012 without BC+. The case comments which were made at the time of Petitioner's contact with the agency in 2012 indicate an intent on the part of the Petitioner to enroll in BC+. There is some inconsistency in the evidence with regard to when her private insurance through [redacted] started. The Petitioner testified it started effective October 1, 2012. [redacted] reported on its verification form that it started January 1, 2014. Based on the insurer's reimbursement to the State for some of Petitioner's medical claims between December, 2012 – January, 2014, it is clear that she had insurance through [redacted] from at least December, 2012. In any case, Petitioner conceded, and the evidence demonstrates, that she had a lapse in employer health insurance beginning September 1, 2012 and that she made a request to enroll in BC+ effective September 1, 2012. Once enrolled, the Petitioner had an affirmative duty to contact the agency to report any changes required by law to be reported and/or to cancel the coverage when she no longer wanted it.

The Petitioner claims she never received the notices issued as noted in Findings of Fact #6 – 9. I do not find this testimony credible. The notices were properly sent by the agency to the correct address for the Petitioner. The notices were not returned to the agency as undelivered.

It is well-established law that the mailing of a letter creates a presumption that the letter was delivered and received. See, *Nack v. State*, 189 Wis. 633, 636, 208 N.W. 487(1926), (citing Wigmore, Evidence)2d. ed.) § 2153; 1 Wigmore, Evidence (2nd ed.) § 95) *Mullen v. Braatz*, 179 Wis. 2d 749, 753, 508 N.W.2d 446(Ct.App.1993); *Solberg v. Sec. of Dept of Health & Human Services*, 583 F.Supp. 1095, 1097 (E.D.Wis.1984); *Hagner v. United States*, 285 U.S. 427, 430, 52. S.Ct. 417, 418(1932). The presumption of delivery and receipt is a rebuttable presumption which merely shifts to the challenging party the burden of presenting credible evidence of non-receipt. *United States v. Freeman*, 402 F.Supp. 1080, 1082(E.D.Wis.1975).

The Petitioner's husband testified that, in September, 2012, he resided in the same condo complex as the Petitioner but in a different unit. He testified that there was a cluster of mailboxes for 20 residents and that he frequently received mail for other residents and his mail went to others. He did not testify that he received the Petitioner's notices from the agency. I find the Petitioner's testimony that she did not receive the notices to be self-serving. I conclude the evidence is not sufficient to rebut the presumption of receipt. The Petitioner testified that she received other notices from the agency that were mailed to the same address. I do not find it credible that the notices from September, 2012 – December, 2013 were the only notices she did not receive.

The Petitioner also testified that she did not tell any of her providers that she had BC+ and that she never received any explanation of benefits from September, 2012 – January, 2014 that told her that BC+ had

paid for her medical services. It is unclear why the medical providers would have billed BC+ if she had not reported her coverage. As far as an explanation of benefits, it is unclear if the Petitioner received any bills or explanation of benefits from her providers, BC+ agency or the private insurer during the overpayment period. EOBs and bills from her medical providers and private insurer would have noted that BC+ had made payment. Without any additional evidence regarding what type of bills or EOBs the Petitioner received from providers or insurers, it is unclear if Petitioner had some additional notice of BC+ coverage from those documents.

The Petitioner alleged an agency error in not terminating BC+ coverage for her children when she stopped paying the $20 monthly premiums that were required through August 31, 2012. As noted earlier, the Petitioner had a lapse of employer-sponsored insurance for at least September, 2012. It is not credible for her to now state that she did not want insurance coverage for her children during that lapse and that she thought their coverage ended when she stopped paying premiums. Further, as noted above, the agency issued a Notice to the Petitioner on September 10, 2012 informing her that the children's coverage continued effective September 1, 2012 with no monthly premium. She no longer owed a premium because she reported her employment had ended and she did not report her new employment or income. Therefore, her argument that the agency erred in not terminating her children's BC+ benefits when she stopped paying the premium has no merit.

The Petitioner asserted that she did report her new employment to the agency when she contacted the agency in August, 2012. There is no evidence that she made such a report to the agency. The worker noted that, if she had reported new employment, the agency would have requested verification of employment status, income and health insurance coverage from [redacted]. There is nothing from Petitioner's contacts with the agency on August 14, 2012 and September 7, 2012 to indicate that she ever reported her new employment and income.

I further note that at the first hearing in this matter on April 28, 2015, the Petitioner testified that she wasn't disputing the fact that there was an overpayment for which she was liable but she wanted time to work with the private insurer to reimburse the State for claims for which she had coverage with the private insurer. Her later testimony disputing her responsibility for the overpayment is less credible given her earlier testimony.

With regard to the amount of the overpayment, this case was held in abeyance for over one year in order to allow the Petitioner, private insurer and State to work through the reimbursement issues. The agency adjusted the overpayment as it received reimbursement from the Petitioner's private insurer. The overpayment has been adjusted as noted in Finding of Fact #16.

BC+ policy instructs the agency, in a "no eligibility" case, to base the overpayment determination on the actual MA/BC+ charges paid, including medical claims paid and/or the capitation rates paid. The policy further instructs the agency how to consider premiums that were paid or should have been paid in the overpayment calculation:

> 28.4.2 Overpayment Amount
>
> Use the actual income that was reported or required to be reported in determining if an overpayment has occurred.
>
> If the case was ineligible for BC+, recover the amount of medical claims paid by the state and/or the capitation rate. Use the ForwardHealth interChange data from the Total Benefits Paid by Medicaid Report(s). Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

> If the case is still eligible for BC+ for the timeframe in question, but there was an increase in the premium, recover the difference between the premiums paid and the amount owed for each month in question. ...

BCPEH, § 28.4.2.

The agency produced evidence from the Petitioner's employer and the child support agency regarding the Petitioner's actual gross household income for the months of the overpayment period. Her income exceeded the reporting requirement (of which the Petitioner had notice in the September 10, 2012 Notice of Decision) of $1,590.83 in September, 2012. She was required to report this income to the agency by October 10, 2012. This would have impacted her benefits beginning November 1, 2012. Her income remained over the program limit through the remaining months of the overpayment period. Therefore, the agency properly started the overpayment period on November 1, 2012.

The agency produced multiple spreadsheets and reports of benefits paid to demonstrate how it calculated the overpayment. The agency spreadsheets show the capitation payments made by the agency on behalf of the Petitioner for her BC+ coverage. They show the medical claims paid by the agency on behalf of the Petitioner. They show the reimbursement received from the private insurer for medical claims and the difference between the paid claims and the reimbursement.

With regard to the overpayment for Petitioner's children, the agency evidence shows the capitation payments made by the agency on behalf of the children for the period of November, 2012 – October, 2013. The agency seeks to recover the amount of these capitation payments. The agency worker testified that the net premiums that would have been owed for the children's coverage during that period, based on the Petitioner's actual income for the period, exceeded the capitation payments. Therefore, the agency is seeking to recover the lesser amount of the capitation payments. For the period of November, 2013 – January, 2014, the capitation payments made on behalf of the children exceeded the premiums that would have been owed so the agency is seeking to recover the amount the Petitioner would have paid in premiums for the children's coverage based on her actual income. I note that the agency is not seeking to recover actual medical claims paid on behalf of the children during the overpayment period in the amount of $6.80 and $40.30.

I find no error in the agency's calculation of the overpayment and the Petitioner has not pointed to any specific error or presented evidence that the calculations are incorrect. I note that I continued to hold the record open in this matter until just prior to issuing the decision based on the Petitioner's assertion that the private insurer intends to provide further reimbursement to the State for some of the remaining medical claims. Per the county agency, as of January 4, 2017, no additional reimbursement had been received from the private insurer. I note that nothing prohibits the private insurer from reimbursing the State for medical claims after the issuance of this decision or making payments toward the overpayment for those claims which would reduce the Petitioner's overpayment liability.

CONCLUSIONS OF LAW

The agency properly seeks to recover an overissuance of BC+ benefits from the Petitioner in the amount of $5,472.42 for the period of November 1, 2012 – January 31, 2014.

THEREFORE, it is **ORDERED**

That the Petitioner's appeal is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 9th day of January, 2017

\s_____
Debra Bursinger
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on January 9, 2017.

Washington County Department of Social Services
Public Assistance Collection Unit
Division of Health Care Access and Accountability
[redacted]